June 2014

Montana Central Tumor Registry Newsletter

Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

Causes of Death among American Indians/Alaska Natives

CDC's Division of Cancer Prevention and Control sponsored a supplemental issue of the *American Journal of Public Health* about the leading causes of death among American Indian/Alaska Native (AI/AN) populations. The authors are experts from many different fields.

Death records and cancer incidence records were linked with Indian Health Service registration data to identify AI/AN people correctly, as they are often incorrectly reported as being members of other racial groups. Previous studies show that nearly 30% of people who identify themselves as AI/AN when living are classified as another race at the time of death. This linkage resulted in the most reliable data to date on causes of death among AI/AN people.

Key findings:

- Among AI/AN people, cancer is the leading cause of death, followed by heart disease. Among other races, it is the opposite.
- Death rates from lung cancer have shown little improvement in AI/AN populations. AI/AN people have the highest prevalence of tobacco use of any population in the United States.
- Deaths from injuries were higher among AI/AN people compared to non-Hispanic whites.
- Suicide rates were nearly 50% higher for AI/AN people compared to non-Hispanic whites, and more frequent among AI/AN males and people younger than age 25.
- Death rates from motor vehicle crashes, poisoning, and falls were two times higher among AI/AN people than for non-Hispanic whites.
- Death rates were higher among AI/AN infants compared to non-Hispanic white infants. Sudden infant death syndrome and unintentional injuries were more common. AI/AN infants were four times more likely to die from pneumonia and influenza.
- By region, the greatest death rates were in the Northern Plains and Southern Plains. The lowest death rates were in the East and the Southwest.

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Meet the Registrar

Claudia Kajin
Rosebud Health Care Center, Forsyth, MT

I am Claudia Kajin and I have been the tumor registrar at Rosebud Health Care Center in Forsyth, MT since 2007. I have been an employee of RHCC since December 1989. I began my adventure in healthcare in the business office. I did patient registration, entered payments, and charges. I moved from the business office to the Health Information Management department in 2004. In January 2005 I became a Certified Professional Coder. I do the coding for the hospital and the long term care facility. In 2007 I became the manager of the HIM department and the tumor registrar. There is always something new and different going on in healthcare. I have enjoyed my different jobs at RHCC.

I have been married to Al Kajin for 41 years. We have lived in Forsyth, MT for 28 years. We have a son and a daughter. Our son, Christopher, lives in Chicago, IL and our daughter, Leslie, lives in Forsyth with her husband Shane.

In my spare time I enjoy target shooting with Al. We enjoy traveling and taking photographs. I put my knitting bag in the car and while Al is doing his thing with the camera I am enjoying the ride and knitting.

The MCTR has again received GOLD Certification

From the NAACCR Office 6-17-2014

NAACCR is pleased to announce that the Montana Central Tumor Registry has attained the **GOLD** standard for quality, completeness, and timeliness for your 2011 data submission!

Congratulations and thank-you for all of your hard work!

Coding Fine Needle Aspiration (FNA)

References: Surgical Diagnostic and Staging Procedure: FORDS page 137 Bullet #6 and the MCTR Manual page 255 Bullet #6.

An FNA is not coded and should not be coded as a biopsy.

Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation*. These are not considered surgical procedures and should not be coded in the DX/Stage Procedure.

RMCDS Software Info

State Backup
When you run the State Backup to send your data to the MCTR, two files are created: ###-ABS and ###-FU (the ### is your hospital number). These two files are saved in the ../Transfer folder so when you browse for your files, this is where they should be. If there is a problem, and there are no files in the ../Transfer folder, the files are also saved in the ../pfiles folder but are named differently. They are named naaccr.p (new case file) and aaccr.p (update file). You can browse for these two files and send them to the MCTR. Then, call RMCDS programmers at 801-581-4307 to troubleshoot and correct the problem.

Conversion to NAACCR Version 14
If you are ready to start abstracting 2014 cases, you should update your software to the most current version and run the Collaborative Stage conversion to version 02.05.50 (NAACCR version 14). Please let Debbi Lemons (dlemons@mt.gov) know if you need instructions to convert your software. The MCTR has not yet converted to version 14 but we can accept your files at this time and will hold them until we are successfully converted.

Certificate of Excellence Recipients

The following facilities received a certificate for the 2014 First Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Rogers Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Helena Dermatology	Helena
Associated Dermatology	Helena
Dermatology Provider of Missoula	Missoula
Hospitals:	
Billings Clinic	Billings
St. Vincent Healthcare	Billings
St. James Hospital	Butte
Teton Medical Center	Choteau
Rosebud Health Center	Forsyth
Frances Mahon Deaconess Hospital	Glasgow
Glendive Medical Center	Glendive
Sletten Cancer Center	Great Falls
Kalispell Regional Medical Center	Kalispell
Central Montana Medical Center	Lewistown
St. Patrick Hospital	Missoula
Clark Fork Valley Hospital	Plains
St. Joseph Medical Center	Polson
Ruby Valley Hospital	Sheridan
Broadwater Health Center	Townsend
Pathology:	
Yellowstone Path Institute	Billings

Common Miscoded Fields Counted on Visual Review Form

For those who missed attending the Montana Cancer Registrars Association meeting in Fairmont Hot Springs, these common miscoded items were presented.

Diagnostic Confirmation

Positive histology and positive cytology are often miscoded. For solid tumors, code 1 when the microscopic dx is based on tissue specimens from a biopsy, surgery, autopsy, D&C, or from aspiration of biopsy of bone marrow. Code 2 when the microscopic dx is based on cytologic examination of cells such as sputum smears, bronchial brushings, bronchial washings, prostatic or breast secretions, fluid samples such as gastric or peritoneal or pleural, urinary sediments, or cervical smears.

CS TS/Ext Evaluation Codes

Staging basis for TURBT is clinical and CS Tumor/Ext Eval should be coded to a 1. This should not be coded to a 3.

Lymphvascular Invasion

In situ is always coded to 0; Lymphomas and Hematopoietics are always coded to 8; unknown primaries are always coded to 9; if lymphvascular invasion is present on the pathology report, code to 1.

Lymph Node Pos/Exam

Lymph nodes positive and examined 98/00 and 00/98 are often interchanged. When there are zero LN's examined, code 98/00 and when there are LN's removed and examined and all are negative but the number is unknown and not documented as sampling or dissection code 00/98. Hematopoietic and lymphoma cases are coded 99/99.

Mets Eval

This item is often mistakenly coded to a 1 when a biopsy of a positive distant metastasis was performed. Instead, code 3 whenever there is positive histology of metastasis.

Multiple Primaries

Bladder: once a patient has an invasive urothelial bladder cancer, a subsequent non-invasive or invasive urothelial bladder cancer is considered the same primary. An in situ primary must occur prior to an invasive urothelial bladder cancer in order to be a separate primary. If it occurs after the malignant tumor, it is not a new primary.

Histology

Colon: MPH Rules H4, H18, H21 give instructions to code histology in a polyp (does not apply to rectum or rectosigmoid). If a polyp is mentioned at all related to this event, it should be coded.

Grade

Solid Tumors: 1) Code to the highest grade even if it's only a focus, 2) Do not code grade from metastatic sites; only the primary, 3) Code grade unknown if the patient had neoadjuvant treatment, 4) unknown primary is always coded 9.

Hematopoietic neoplasms: use the Hematopoietic Database to code grade.

Treatment

Chemotherapy: When coding CHOP, many forget to add the P (Prednisone) as a hormone treatment. When coding 5FU and Leucovorin, many often code this as a combination chemo. It should be a single agent since the Leucovorin is ancillary. Use the Seer Rx to look up any drugs.

Melanoma: Clear margins are very important and will determine surgical code. Codes in the 30-36 range are used generally when clear margins are not mentioned or are 1cm or less. The codes in the 45-47 range are used when clear margins are mentioned and are greater than 1cm.

Lymphoma: If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02 in Surgical Diagnostic and Staging Procedure field. If that node resected is the only node diagnosed with lymphoma, use the Surgical Procedure of the Primary Site code for the lymphoma primary - 25.